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ABSTRACT

The intent of this manual is to provide counselors with essential background information about alcohol abuse among blacks and with a practical, workable model for organizing and structuring a training program. A general discussion of black self-awareness in relation to alcohol abuse is presented. An approach to counseling and serving the black alcoholic is suggested. A model program for training persons who will be working with black alcoholics and alcohol abusers is outlined. A general alcohol education program for use in training alcohol abuse counselors is also outlined. Included is a black vocabulary test and an alcohol awareness test that can be used for pre-training assessment of the counselor's needs and post-training evaluation of the effectiveness of the program. A bibliography of pertinent printed materials and a list of available films and audio-visual aids are provided. (Author/EB)

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ALCOHOL ABUSE TRAINING

Relevant To Minority Populations

HANDBOOK: BLACKS

Developed for

A Special Training Grant

From Southern Area Alcohol Education and Training Program, Inc.

By: Memphis State University
College of Education
Department of Special Education and Rehabilitation

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PREFACE

This manual has been designed primarily for use by persons employed in alcohol abuse programs who are involved in training others–concerned caregivers, interested citizens, and individuals from other helping professions–to understand better the special problems associated with alcohol abuse among American Blacks and to meet the special needs of this minority population. The intent of the manual is to provide trainers with essential background information about alcohol abuse among Blacks and with a practical, workable model for organizing and structuring a training program.

The manual is in four parts: (1) a general discussion of Black self-awareness in relation to alcohol abuse and a suggested approach to counseling and serving the Black alcoholic; (2) a modular outline of a model program for training persons who will be working with Black alcoholics and alcohol abusers; (3) a modular outline of a general alcohol education program for use in training alcohol abuse *trainers*, including an alcohol awareness test which can be used for pre-training assessment of the trainers' needs and post-training evaluation of the effectiveness of the program; (4) a bibliography of pertinent printed materials and a list of available films and audio-visual aids.

It is hoped that the material in this manual will help trainers to identify the special problems of Black alcoholics, to structure a training program which will help prepare trainees to understand and meet those needs, and to recognize the variety of educational resources available to them.

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MAKE IT EASY ON YOURSELF: SELF-IMAGES RELATED TO DECISION- MAKING

Whether we are conscious of it or not, our daily behavior is largely determined by the way we see ourselves, who we think we are, what we believe we are capable of doing or not doing. How we feel about ourselves–whether we feel that we are on top of the world or that the world is on top of us–largely determines our next actions. And the result of these actions influences our self-image–how we feel about ourselves.

If a man believes he can run 15 miles, sooner or later he must test out his belief or abandon his self-image as a long-distance runner. If he tries and runs out of breath after mile 3, his actions will change his belief about himself. But what if he succeeds? Not only will his self-image as a long-distance runner be reinforced, but he will try it again, maybe setting a new goal of 20 miles. In other words, there is a relationship between what he believes he is and what he can do.

Our self-image is formed gradually over a long period of time. Often it is difficult to change. It begins to be formed in those first moments of conscious awareness as an infant. It is shaped through childhood, changed and reinforced during the teen years, and by the time we are adults, it has become the sum total of all those feelings from all those events long past in our lives.

Throughout our lives we are presented with ideas and information about ourselves, including what others say about us and to us, how they react to what we do, what they expect of us, and what we are considered capable of doing. Often this information about ourselves is valid; other times we can check it out for ourselves, as in the long-distance runner example. But other information that we receive may be untrue and unmotivated–consciously or unconsciously–by the larger society's need to define Blacks.

We are confronted with information and ideas from our families, our friends, the media, society at large. If we accept this information about ourselves without question, some of our ideas about who we are may be inaccurate. The more we clarify our own definition of ourselves and reduce our dependence upon other people's definitions–and the accompanying conditions that keep us oppressed–the better we can examine our options and make our own decisions about things that affect our own lives.

During the course of our lives we have to make decisions: which job to choose, whether to marry or not, whether or not to continue our education, whether to move to a new community or not. A lot of these decisions will be a direct result of how we feel about ourselves.

There are many people who have a low opinion of themselves. Some feel they have no contribution to make to their families or to their communities or to anyone. Usually if a person feels that he or she has nothing to offer, he is apt to make decisions and act according to this low opinion of himself.

For instance, there are very capable people who believe that they cannot hold a job. They expect to be laid off or fired, so they perform as if they are on their way out anyway–and pretty soon they are out because of poor performance, not lack of ability. Unfortunately, such a person is likely to see this as one more example of his self-image as a loser, and the vicious cycle of negative image and negative actions is very likely to continue.

On the other hand, individuals who feel good about themselves and feel that they have a contribution to make to their families, communities, and jobs are more likely to make positive decisions and act in ways that will have positive consequences on their lives.

Many people do not make a deliberate choice to drink or not to drink. Such people slip into their drinking or non-drinking habits by chance. The decision to drink or not to drink grows out of many influences: the national and cultural history of alcohol use and the attitudes that have accompanied it; the way drinking is presented to us in the popular media and advertising; the attitudes and behaviors of our families and friends toward alcohol; and most important of all, how we see ourselves in relation to the decisions we make and the actions we take.

People who have positive self-images are more likely to make positive and responsible decisions about things that affect their lives, including drinking. People who know who they are and how they came to be themselves and where they are going are in a position to know how to answer questions like these to their own benefit:

> How do you feel about yourself as a Black person?
>
> When you feel a certain amount of stress, depression, boredom, or loneliness, do you ignore it and hope that the feeling will go away, or do you work to understand and deal with those feelings?
>
> If you drink, do you feel that you have consciously and freely chosen to drink?
>
> If you do drink, why do you drink? From habit? Because it is expected? To be part of the crowd? To ease feelings of stress? Because you're bored? When something upsets you? To become less inhibited?
>
> If you do drink, are your drinking patterns ones you would like to encourage in younger Black people?

For many people, consciously evaluating the appropriateness of their own activities and decisions is an awakening. For years, Blacks were conditioned to accept traditional social expectations–and the myths society held about them. For many the process of discovering one's self-image is very painful as well as very rewarding.

Drinking practices are a matter of individual decision. As individuals we can decide to use, or not use, alcohol in ways that are helpful to us. If we choose to drink, we must determine what, for us, is sensible drinking. If we choose not to drink, we should see this as a course of action we are free to follow, regardless of what other people do.

Mixed messages often lead to drinking problems. And Black people are often exposed to mixed messages. Therefore, our decisions about drinking are as important as the other major decisions in our life.

With the 60's came a cultural revolution in Black communities across the United States. This revolution had an impact on the total American society. The history of Blacks in America has been a history of roles defined by, and in the interest of, white America. Black people are making a break with these past roles. Being Black is being proud. Being Black is beautiful. Above all, being Black means defining one's own identity and role in the human community.

Black people are constantly being bombarded with images that imply who they are. Images of Black people are presented on television, on radio, in books, and through government reports. We are all familiar with authorities telling us who we are. We have been defined usually as a problem or as the source of a problem. But seldom have we been defined as a people.

We must be alert to all these various messages that are presented to and about us. And by being alert we can better make a distinction between myths projected by others, and realities which are true reflections of our culture and historical origin. As a result of making these distinctions, we are better able to establish our own values and determine our own destiny.

BLACK ALCOHOLISM: SOME QUESTIONS AND ANSWERS

[This section is taken from a summary of discussions and papers presented at at 1975 symposium on Black alcoholism sponsored by the Alcoholism Training Program at the Atlanta University School of Social Work, Atlanta, Georgia.]

I. To what extent can the Black alcoholic be compared with the White alcoholic?

   A. The physical conditions of alcoholism require the recognition that "an alcoholic is an alcoholic is an alcoholic." Consequently, the need to physically dry out the alcoholic and deal with his biological problems must be dealt with immediately whether the alcoholic is Black or White.

   B. There are important differences between the Black and White alcoholic which limit the validity of making comparisons. Consequently, comparisons should be minimized in determining the nature of the alcoholic problem.

II. What are the major differences between the Black and White alcoholic?

   A. Blacks suffer from more stress as a result of racism and, thus, they are more prone to become alcoholics than Whites.

   B. The history of this racial oppression has created other conditions which create a propensity towards alcoholism.

   C. In terms of concrete examples, Blacks enter treatment more through legal systems than Whites and Blacks.

   D. Physical deterioration is greater in Blacks than Whites at the point of treatment entry.

III. What is the social context of Black alcoholism and what implications does this context have for treatment?

   A. Black alcoholism cannot be viewed out of context of the total Black community. Therefore the treatment of the Black alcoholic must be placed in context of the development of the Black community. Depending on the direction of Black communities change, alcoholism may increase or decrease. Thus, solutions to problems of racial and economic oppression have implications for the solution to Black alcoholism.

   B. In the light of Black community development, treatment must take into consideration the biological element and the political element which includes such factors as White control of Black treatment facilities and the fact that the prevention of alcoholism was not a part of any federal mandate. Federal legislation is geared toward getting the alcoholic off the street as opposed to eliminating alcoholism.

   C. The only Black alcoholic being researched is the lower income, visible, Black alcoholic. The middle class Black alcoholic is absent from treatment programs. This is, in part, caused by federal legislation which identifies the service target as the visible alcoholic.

   D. The availability of alcohol to Blacks is higher than to Whites. A geographic assessment of liquor stores indicates a higher proportion in Black residential areas than in White residential areas. This makes alcoholism, particularly in low income Black areas, a profit making phenomenon. This must be considered in the political-economic context of Black community development.

IV. What should be the treatment objectives of the Black alcoholic?

A. If we limit our treatment programs to the physical and psychological aspects of alcoholism, then the "product" of treatment is a symptomless, but still an oppressed, Black person.

B. A lead must be taken from some of the Black drug programs which have established a treatment outcome as a person who is not only drug free, but also prepared to struggle to eliminate those conditions which created his addiction.

C. We need to develop in our curriculum development process, an ideology of Black alcoholism, which not only identifies the systematic and personal forces which lead to Black alcoholism, but also specifies the characteristics of the alcoholic personality. A major component of this ideology should be the recognition that the alcoholic is a person and should be approached as a person and not a misfit or deviant.

V. What resources and mechanisms currently exist within the Black community that can be utilized in the treatment process?

A. The various political activities which seek to obtain certain rights for Black people can in fact be therapeutic in that, for many, they provide some tangible life goals and objectives.

B. The Black religious experience should be examined closely for those aspects which provide spiritual and material strength to personality development. The Muslim experience in rehabilitating drug and alcohol dependents should be examined closely for both its religious and material supports which have been successful.

C. The Alcoholics Anonymous model is of question to Black people in that it tends to be an exclusive White middle class club. However, certain aspects of it may be adopted.

D. The extended family experiences of Black people should be utilized in developing the necessary support systems for treating the Black alcoholic.

E. Where there exists no treatment facility specifically designed for the Black alcoholic, community groups, including political, church, civic, and recreational organizations should be utilized to watchdog available treatment facilities, serve as advocates for those receiving treatment, and conduct outreach services in that organization's day to day activities.

VI. What other problems exist in reference to current treatment programs which should be given serious attention in curriculum development?

A. The referral system for alcoholic treatment is replete with racism. Blacks often are not referred for treatment by Black or White professionals.

B. Current funding patterns do not facilitate the development of prevention programs. Consequently, alcoholism programs are after the fact efforts.

COUNSELING FROM YOUR BLACK BAG... OR COUNSELING FROM A CULTURAL PERSPECTIVE

[The following is written from a paper by William H. Wheeler, Ph.D., A.L. Nellum and Associates, Inc., 151 Ellis Street, Suite 429, Atlanta, Georgia 30303]

In this paper, I will advance the position that one cannot be an effective counselor unless he or she is skilled in counseling from the "cultural perspective" of the client. I further argue that there are characteristics which may be generally attributed to prospective Black clients. These characteristics, I suggest, are incompatible with the traditional counseling relationship. And finally, I note that there are several nonverbal clues which can either improve or inhibit the relationship with a Black client. I call these, "Do's and Don'ts of Counseling Black Clients."

Prior to advancing a position on cultural perspectives to counseling with an emphasis on counseling Black clients, one must deal with two myths. These well-implanted myths permeate the approaches of far too many counseling practitioners. I purposely distinguish between practitioners and theorists. As suggested by Jones and Jones (1970) in "The Neglected Client", it is usually the practice and not the theory which falls short of meeting Black needs.

The first myth is that there is no unique Black or Afro-American culture in this country. When taken to its obvious conclusion, this myth ultimately snowballs into the moronic melting pot theory. American scholars (Black and White) have long since rejected the melting pot for the more euphemistic "salad bowl." Cultural pluralism has been divorced of much of the enmity heretofore associated with it. The Black or Afro-American culture is only one of many cultures which interface with each other in American society. Acceptance of this basic premise is essential if the second myth is to be buried. The second myth is simply that counseling is the same regardless of the ethnic or cultural background of the client. Proponents of this position note that people are people and a humanistically oriented approach will suffice for all.

A definition of terms is important if we are to proceed further. In an effort to operationalize the terms "culture" and "counseling" I have borrowed from the works of Wallace (1961) and Krumboltz (1969). Wallace for example, defines culture in a workable probabilistic mood as:

> Those ways of behavior or techniques of solving problems which being more frequently and more closely approximated than other ways; can be said to have a high probability of use by individual members of society.

Wallace's definition allows us to look at measurable variables such as behaviors and problem solving techniques. Implicit in his frequency count and measures of probability is the fact that these behaviors and techniques, though shared across cultural lines, can be utilized to characterize a particular culture.

One can infer the impact of culture on counseling in noting Krumboltz's generic definition of counseling:

> Counseling consists of whatever ethical activities a counselor undertakes in an effort to help the client engage in those types of behavior which will lead to resolution of the clients problem.

If cultures can in fact be characterized by behaviors and problem solving techniques, and if counseling is in effect an effort to help the client engage in these very things it would then seem that culture and counseling are indubitably linked. If we as counselors are to be effective helping agents in this process which involves client's culture, can we afford to ignore that culture? The question is clearly rhetorical. The client's culture must play a significant role in the formulation of any counseling approach which is to be both relevant to and effective with him.

This concept is by no means new or unique. Counseling theorists have traditionally taken into consideration the culture of White, middle-class, American males when developing modalities. Blacks and others who share different cultural characteristics have been shaped and molded by these traditionalists until they either adopt the majority's view or abandon the counseling process. Neither of these is a viable alternative as this author perceives it. I believe counseling can in fact be made both relevant and effective with Black clients in particular. As professionals, we have a responsibility to modify our discipline to meet these goals.

Modification does not suggest a total rejection of existing counseling modalities. It is rather believed that each modality has something to offer when considered within the cultural framework of the client. Thus, I am arguing that one cannot hope to be a pure Rogerian, Reality Therapist, Rational Emotive Therapist or any other kind of therapist and be successful with Blacks. There are those who will reply that such a position is of little value since one cannot work effectively with White clients if he uses only one modality. My retort is two-fold: first, my experience has been that counselors (especially novice counselors) will identify one theorist and attempt to mimic his or her style. Secondly, if traditional modes are rejected for more eclectic approaches to counseling Blacks then surely Whites will benefit from the experience. As the father of Black Psychology (Charles Thomas, 1971) often says, "if it's good for Blacks, others will benefit." There are certainly subcultural patterns among even White Americans which would lend themselves to changes in traditional counseling approaches.

As I begin to make suggestions about possible changes in counseling techniques one must keep in mind that much of it is based on speculation about unique characteristics of Black clients. Such research could accurately identify those characteristics which can be taken into consideration to improve the counseling experience for Blacks.

An example of this research is in the area of "willingness to self-disclose", Jourard & Lasakow (1958). White women were found to be the most willing to self-disclose, followed in willingness by White men, Black women and finally Black men. How does one use this knowledge in counseling Black clients, and Black men in particular since they seem to be the least prone to self-disclosure? Let me first suggest a pitfall one must avoid. One should not assume mental deficiency, feelings of inferiority or even fear of the counseling relationship on the part of the Black client. Such assumptions would undoubtedly be reflected in ones condescending demeanor. On the other hand, one would probably not utilize a non-directive approach in working with such a client unless he had an extremely high tolerance for "silence." Such a Black client would probably respond more readily to a directive counselor who could actively help him identify and explore several options to resolving his problems. This is the kind of Black who after you paraphrase just right, just the way they taught you in Coun. 603, responds, "how come you keep repeating what I just said!?" In your mind you say, "this never happened to me when I role played in class!" The problem is, most of your Black clients have not read the script. They do not know how to be traditional clients; so you must become a non-traditional counselor if you are to be successful.

Many practitioners have discovered at their respective institutions that Black clients simply do not come in for counseling with the frequency that Whites do. And when they come in they are more likely not to return. Several obstacles may be operating here; I will explore a few of them.

It has been my experience and that of many of my colleagues that the following Black characteristics are non-conducive to the traditional counseling relationship:

1. Blacks have been socialized to handle their own problems. Most Blacks have few if any "positive" encounters with helping agencies early in their development. The "street mentality," which is a heavy influence on many Blacks, defines

one as "weak" if one cannot deal effectively with any situation he is confronted with. Black men seem to be effected even more than Black women by this need to resolve their own problems. This manifests itself in the fact that even when Black women have been convinced to see a counselor their men often refuse to go with them.

2. Related to the first characteristics is the fact that many Blacks perceive those who do see counselors as "sick." This labeling further deters one from counseling. It is not at all unusual to have Black clients ask during a session, "I'm not really sick, am I?"

3. Another discouraging factor for many Blacks who might consider the counseling relationship is the fact that their "business will be put in the street." This is the whole issue of confidentiality. Actually it is not difficult to understand if one accepts the earlier positions. If Blacks have in fact placed expectations on themselves which dictate self-resolution of problems; and if clients are perceived as sick or at least weak, then surely one would not want others (peers) to know of his particular weakness. And thus we hear Black clients make statements like, "you're not going to tell anyone about this, are you? Or,does anyone have to know that I'm here?" Once again, the "street mentality" dictates a defensive posture concerning one's personal life.

4. In spite of these barriers some Blacks will give counseling a try. Too often these clients do not return for a second session. It is my contention that they have been turned off to the counseling experience; made to believe they should have resolved their own problems and sent back to their communities to "turn off" others. Their counselor in all probability failed to consider their cultural milieu in the counseling experience. These are the clients who report, "somethings wrong with that 'dude', he gets right up in your face when he talks to you. Or, he makes me nervous; he just keeps looking at me. Or, what's wrong with him, he keeps on touching me. Or, all he ever does is repeat what I say."

If your mental health agency is not attracting Black clients one or more above may be occuring. If the problem is related to numbers one through three, this may be remedied by improving your image among the population of potential Black clients, while re-educating them to the counseling process. The last item will probably require considerable re-education of your staff. I will conclude with several suggestions in that area.

Do's and Don'ts of Counseling Black Clients

Let me preface this section by indicating that each of these is a generalization and although they may apply in many of your counseling relationships, there are few absolute truths when one deals with people.

Eye Contact

Carl Rogers (1951) suggests that eye contact is essential to attending behavior. Most of us are taught very early in our counselor training that we must maintain eye contact with the client. We then discover that our Black clients look at the floor, the ceiling, the wall, any place but in our eyes. Too often we assume that the Black client will not maintain eye contact for one or more of the following reasons:

a. he feels inferior
b. he identifies me as an authority figure
c. he is afraid of me
d. he knows he does not speak well
e. etc....

One who counsels from a cultural perspective would take into consideration the fact that Black children will often learn a different "script" than their White counterparts related to eye contact. White children often report that their fathers' comment during a disciplining session was, "look at me when I'm talking to you!" or something to that effect. Black children on the other hand heard comments like, "don't roll your eyes at me!" These messages in time will control how an individual uses eye contact. The message is further reinforced in the street for Black youths, where the "script" is definitely one of no steady eye contact among same sexed individuals unless there is a confrontation. A Black male who has left his part of town knows that eye contact held for only seconds can mean immediate confrontation. An observer, watching two Black males "playing the dozens" knows that it is only a game until the participants begin staring at each other. The eye contact is a sure indication of confrontation. The first one to look away has lost the confrontation.

Given this kind of socialization it is not unusual that Black clients do not choose to maintain eye contact in a counseling session. Nor is it unusual that many Black clients will become restless and uncomfortable when they realize that their counselor is "staring" (which is how they may interpret eye contact) at them. Do we as counselors have a right to impose our values on our clients? And have we won him over or lost him when he does return our eye contact?

Social Distance

Social distance might be loosely defined as that space identified as acceptable to operate within between two people. Naturally many variables will effect the acceptable social distance. The sex of the two individuals will have an impact, as well as, the nature of the interaction. I contend further that the culture will often determine acceptable social distance. I believe that Blacks define about one arms length as acceptable social distance for holding conversations between individuals of the same sex. Whites, on the other hand, seem to operate within about half of this distance. Many of us have observed the reaction when individuals with incompatible "social distance values" hold a conversation. One of the pair seems to be backing up constantly to his comfortable distance, while the other seems to be chasing him around the room. This is a comical set of events until the chaser becomes a White counselor trying to establish a rapport with his ever retreating Black client. The counselor in this position has once again failed to counsel from a cultural perspective and is imposing his values on the client.

Barriers (physical objects)

The "ideal" counselor's office is set up with at least two comfortable chairs, an end table and a lamp. The desk is usually an innocuous object, used to answer the phone and do paper work, but never to be sat behind while serving a client. Sitting behind a desk during a counseling session is akin to putting a physical barrier between the counselor and client. Communication will be stifled by the object. The client will use it as a crutch, hide behind it and use it to increase the distance between himself and the counselor. These are all very traditional ideas which most of use were probably bombarded with during our counselor training. I contend that we must re-evaluate this position when working with Black clients. I have found for example that my Black male clients, given the option, chose the seat on the other side of the desk over the comfortable chairs facing each other. Further, I found that communication was not stifled but rather facilitated in the seats arranged around the desk. I was forced to re-evaluate what I had learned. I concluded that the traditional seating arrangement made communication easier for me and not necessarily for my clients. Again I ask, should we impose our values on the client?

Touching

Most of us learn during our counselor training to utilize touch as additional dimension of communication. Unfortunately some of us do not realize that what we say with our touch is not at all what we mean to communicate. Once again, I contend that one's culture will influence both his touching

behavior and his reaction to being touched. It is my position that Black men are less accepting of other men touching them in a counseling relationship than are their White counterparts. Thus we find the well meaning White counselor who attempts to communicate empathy by reaching over and "patting" the knee of his Black male client. The client squirms and wonders to himself about the intensions of the counselor. If this occurs too often the Black client is likely to withdraw or simply not return to counseling. The message here is not that Blacks are not touch oriented, but rather that touching in certain situations will carry very specific connotations. If counselors are to be effective they must be aware of this, and again take care in not imposing their values.

* * *

The four (4) Do's and Don'ts listed above are only a few in a wide array of behaviors with cultural implications which can be utilized to enhance the counseling relationship or misused to stifle the relationship. If one adds the variable of different sexes between counselor and client then, a different set of predictable behaviors may occur. Surely the ethnic background of the counselor will also effect the client's reaction.

I believe that counselors must utilize the volumes of research conducted on Black culture and life styles and apply this knowledge to the counseling relationship. I firmly believe that those of us who have had Black experiences must learn to integrate those experiences with our professional training. The goal is to develop a counseling approach which can in fact be both relevant to and effective with Black clients.

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BLACKS AND ALCOHOL ABUSE: A TRAINING PROGRAM

Introduction

This program can be easily adapted to meet the training needs of both lay and professional groups. Training should take place in a setting which could comfortably accommodate the size of the group and the manner in which the training components are to be presented. A setting in the Black community would be ideal because it would give participants a better feel for the community and they could more readily identify with the content of the presentation.

This material can be presented in the form of workshops, seminars, in-service training programs, or lectures. Enabling activities such as films, role playing, small group discussions, psychodrama, handout-materials, flip charts, chalk boards, short quizzes, etc., will greatly enhance the presentation.

The training sessions should be limited to fifteen individuals to allow for maximum participation.

Module I: Communication

Objectives

To provide participants with certain helping skills to enable them to communicate effectively with the Black population.

Enabling Activities:

1. Give "Black Vocabulary Test" (Appended to this training program)
2. Introduction
   (a) Define communication
   (b) Illustrate a breakdown in communication
3. Dealing with obstacles
   (a) Amount you talk
   (b) Eye contact and touching
   (c) Gesture and body language
   (d) Interruptions
   (e) Turning clients off
4. Review Black Vocabulary Test

Module II: Values and Value Systems

Objectives

To investigate the value systems of the Black minority.

Enabling Activities:

Presentation and Discussion on:

1. Values (introduction)
   (a) Define values
   (b) Values are intangible
   (c) Values are important
   (d) Values can change
2. How do we obtain values
   (a) Family
   (b) Economic and social
   (c) Peers
3. Valuing processes
   (a) Choosing
   (b) Prizing
   (c) Acting
4. Areas of value conflicts and confusion among Blacks

Module III: Alcoholism in the Black Community

Objective

To investigate the use and abuse of alcohol in the Black community.

Enabling Activities:

Presentation and Trainee Discussion on:

1. General considerations
   (a) Etiology of alcoholism among Blacks
   (b) Incidence of alcoholism among Blacks
2. Interrelationships between alcohol-related disorders and other medical problems (discussed as possibility, early diagnosis)
3. Why do Blacks drink:
   (a) Equality-freedom
   (b) Use of leisure time
   (c) Adaptive behavior-"sipping"
   (d) Prestige symbol
   (e) Escape
   (f) Immediate pleasure

Module IV: Racial Barriers in the Counseling Relationship

Objective

To help participants become more aware of the feelings and attitudes that impede client-worker relationships.

Enabling Activities:

Presentation/Role Playing on:

1. The Racial Factor in the Interview
   (a) The problem of racial differences between worker and client explored.
   (b) Consideration of matching client and counselor.
2. Use of paraprofessionals–pros and cons
3. Client preferences

Module V: Community Resources and Program Planning

Objective

To increase the skills of participants in identifying and mobilizing resources to meet the needs of the Black alcoholic.

Enabling Activities:

Task Force Groups to Assess and Plan Needs and Resources Through:

1. Defining special objectives of alcoholism programs for members of the Black community.
   (a) Make alcoholism services more meaningful for Blacks.
   (b) Help Blacks become more receptive to alcoholism services and increase utilization of existing services.
   (c) Raise hope for improving the quality of life through tangible services and increased sense of self-esteem.
2. Identifying specific needs of the Black community, in addition to alcohol education and treatment.
   (a) Housing

(b) Transportation

(c) Education and training

(d) Employment

(e) Income levels

(f) Health services

(g) Recreation-use of leisure time

3. Setting policies and procedures to increase the impact of alcoholism services on members of the Black Community.

(a) Establish administrative and cooperative agreements between agencies delivering alcoholism services and agencies delivering specialized supporting services such as detoxification, job placement, financial assistance, etc.

(b) Select, train and make use of indigenous non-professionals to work with members of minority groups.

(c) Prompt service accessibility to members of the Black community through service locations, decentralization of services, and provisions for transportation when needed.

(d) Make use of home visits when appropriate for crisis intervention with the aid of paraprofessionals.

4. After task force groups have completed the above, then come back into the large training group and discuss findings and make recommendations.

BLACK VOCABULARY TEST

1. To say "Give me a play" means to give:
   (A) a chance
   (B) a hand shake
   (C) an invitation
   (D) encouragement

2. To say that something is good, Blacks say that it is:
   (A) mellow
   (B) groovy
   (C) lonely
   (D) straight

3. A common way Blacks address a girl is:
   (A) good-morning
   (B) hey chick
   (C) say hammer
   (D) hey beautiful

4. When Blacks say they are "rapping" they mean:
   (A) hitting someone
   (B) talking
   (C) knocking
   (D) prison term

5. To be well dressed is to be:
   (A) pressed
   (B) draped
   (C) clean
   (D) conditioned

6. To say someone is "sidditty" is to imply that he thinks he is:
   (A) better
   (B) good-looking
   (C) rich
   (D) superior

7. What is a "set":
   (A) a group
   (B) a party
   (C) a gang
   (D) a stage

8. When someone's jaws are tight he is:
   (A) fearful
   (B) angry
   (C) strong
   (D) hugging

9. To say someone is "heavy" means he is:
   (A) overweight
   (B) thin
   (C) intelligent
   (D) good-looking

10. A synonym for car is:
    (A) wheels
    (B) short
    (C) ride
    (D) machine

11. A "Box" is a:
    (A) car
    (B) casket
    (C) wooden box
    (D) a hi-fi

12. A very attractive female is:
    (A) a babe
    (B) a cutie
    (C) a swinger
    (D) a fox

13. To describe a girl with a beautiful figure it is said she is:
    (A) a looker
    (B) hip
    (C) a swinger
    (D) fat (phat)

14. Which word is most out placed:
    (A) squib
    (B) blood
    (C) gray
    (D) spook

15. A "jam" is:
    (A) a fix
    (B) shoes
    (C) a dance
    (D) a record

ANSWER KEY

1. C
2. A
3. C
4. B
5. C
6. D
7. B
8. B
9. C
10. B
11. D
12. D
13. D
14. C
15. D

TRAINING TRAINERS FOR MINORITY POPULATIONS

Introduction

The purpose of this training program is to teach the skills needed by Alcohol and Drug Trainers in conveying information concerning alcohol and other drugs to audiences that may consist of substance abusers, their families, interested others and the general public. Often trainers are asked to disseminate relevant information aimed at increasing the awareness, receptivity and sensitivity of the community and stimulate social action in order to increase the services provided for people with problems associated with the use of alcohol. These persons are often not trained in effective utilization of training strategies such as: planning an alcohol education program curriculum; using the mass media and institutional channels of communication; selecting printed and visual materials and, creating and developing materials tailored to meet the needs of the minority populations. In order for trainers to accomplish these tasks efficiently, it is imperative that they possess skills in the following areas:

1) Interpersonal communication
2) Knowledge of alcohol and other drug related problems related to minority populations
3) Treatment strategies
4) Group interaction
5) Planning
6) Assessment and evaluation

Suggested Training Modules

Module I - Alcohol Information and Education
Training time: 3 hours

A. Philosophy of Alcohol Education
   1) what is it?
   2) who needs it?
   3) why is it needed?
   4) how is it given?

B. Major Issues in Alcohol Education
   1) alcoholism vs. problem drinking
   2) major approaches to alcohol education
      a) values clarification
      b) factual information
      c) scare tactics
      d) abstinence vs. responsible drinking
   3) church/family/community/school (who should teach about alcohol?)

Module II - Alcoholism and Alcohol Abuse in Minority Populations
Training time: 3 hours

A. Cultural aspects of alcohol problems related to:
   1) Blacks
   2) females
   3) youth
   4) aged
   5) Spanish-speaking Americans
   6) rural Americans
   7) American Indians

Module III - Instructional Planning
Training time: 2 hours

A. Planning your curriculum
   1) topics to be covered - related to specific needs of trainees
   2) utilizing local professionals as trainers
      a) alcohol and drug counselors
      b) mental health personnel
      c) medical personnel

3) resource materials

   a) National Institute on Alcoholism and Alcohol Abuse Clearinghouse (see Resources Chapter in Training Manual)

   b) posters, displays, etc.

   c) audio-visual aids

4) methods of presentation

   a) workshops

   b) seminars

   c) panels

5) public relations (local newspapers, radios, church and civic groups, newsletters)

6) physical facilities

   a) local training sessions in community

   b) consider using local churches, hospitals, schools, etc.

   c) arrange for coffee, pastries, etc.

Module IV - Selection of Trainee Population
Training time: 2 hours

A. Minority groups

B. Church and civic organizations

C. Community leaders

D. Medical agencies

E. Clergy

F. Interested citizens

Module V - Assessment and Evaluation
Assessment administration: 1 hour

A. Assess needs of trainee populations

B. Do pre- and post tests to evaluate training effectiveness in meeting needs (see Alcohol Awareness Scale - Section XI)

Section XI

ALCOHOL AWARENESS SCALE
Form A and Form B

Form A
and
Answer Key

ALCOHOL AWARENESS SCALE

Age: _____

Sex: M____ F____

Education:
( ) Grade School
( ) High School
( ) Some College
( ) College Graduate
( ) Post Graduate

Drinking Patterns:
( ) Never
( ) Occasionally - 3 or 4 times a year
( ) Often - every week
( ) Quite Often - every day

Race: ( ) White ( ) Black ( ) Other

Occupation: _____
(If student, indicate "Student")

Do you in any professional capacity work with individuals with drinking problems?
( ) Yes ( ) No

Instructions:

Below are listed some statements about alcohol. You are to indicate whether you agree or disagree with the statements *as stated* based upon your own knowledge, experience and your feelings. The statements are listed under certain headings (example, *Psychological/Emotional*). These headings are for classification and scoring purposes only; do not be concerned with them. Please respond to *ALL* statements.

Psychological/Emotional Aspects

1. Alcohol is helpful in relieving tension and stress.
2. Alcohol helps a shy person to be more confident.
3. Alcohol is a "downer" since it calms your nerves.
4. Most alcoholics drink alone.
5. Drinking is a good way to avoid facing personal problems.
6. The family can offer help and support to the alcoholic member.
7. Never trust a man (woman) who doesn't drink.
8. A few drinks help one to relax and unwind.
9. People are friendlier when they drink.
10. Being emotionally dependent (mind) on alcohol is the same as being physically dependent (body) on it.
11. Fear and depression are not really important in causing drinking problems.
12. A recovered alcoholic can be completely "dried out" from a medical viewpoint without investigating his psychological problems.

Social/Religious Aspects

13. Derelicts (bums) on skid row represent the largest number of alcoholics.
14. It is rude to refuse a drink of alcohol.
15. Alcoholism is basically a spiritual problem.
16. Alcoholism is more common to middle-ages (40-60) and older persons (61 and above).
17. In society today there are more "hard" drug addicts than alcoholics.
18. The first round of drinks should be a double or two beers to "break the ice."
19. A good religious background will stop a person from drinking.
20. It is impolite to tell a friend that they are drinking too much.
21. You can always tell an alcoholic by the way they drink at parties or beer joints.
22. There are no known alcoholics below the age of 18.
23. If parents don't drink, their children will probably never develop drinking problems.
24. The best time to teach children about alcohol is as they approach the legal age to drink.
25. In the U.S., 7 out of 10 adults drink alcoholic beverages.
26. Women hardly ever become alcoholics.

Legal Aspects

27. Alcohol addiction is legally considered a disease.
28. Alcoholic patients committed by courts or family members to a psychiatric hospital or clinic lose many of their civil rights.
29. In reality, not many traffic deaths can be linked with alcohol.
30. Alcohol and crime are rarely related to each other.
31. Drunken driving is a major social problem in our society.
32. The alcoholic cannot assume responsibility for his own behavior.
33. In most states public drunkenness is a crime.
34. In 1970, Congress established the National Institute of Alcohol Abuse and Alcoholism.
35. Alcoholism is listed as the primary cause of death on more than 15,000 death certificates yearly.
36. A blood alcohol concentration of 0.10% constitutes legal drunkenness in most states.

37. The "drunk tank" (jail) is a good cure for alcoholism.
38. As few as three drinks can interfere with a persons' ability to drive.

Health Aspects

39. Alcohol helps the brain function better.
40. You can never really get drunk on beer.
41. Alcohol can combat or fight infection.
42. No harmful effects can come from drinking if one eats right.
43. Antabuse is a medicine that makes you sick if you drink after taking it.
44. Mixing different kinds of drinks causes hangovers.
45. It is impossible for one to die solely from drinking.
46. If a person consumes a pint of hard liquor or its equivalent every day, he can be labeled "an alcoholic."
47. Cirrhosis (hardening) of the liver occurs about as often in non-alcoholics as in alcoholics.
48. Alcohol is a food substance since it is a source of calories.
49. Alcoholism is a disease which almost always becomes worse.
50. If you can hold your liquor, you'll never become an alcoholic.

ALCOHOL AWARENESS SCALE

Form B

Age: ____

Sex: M ____ F ____

Education:
( ) Grade School
( ) High School
( ) Some College
( ) College Graduate
( ) Post Graduate

Drinking Patterns:
( ) Never
( ) Occasionally - 3 or 4 times a year
( ) Often - every week
( ) Quite Often - every day

Race: ( ) White ( ) Black ( ) Other ____

Occupation: _____

(If student, indicate "Student")

Do you in any professional capacity work with individuals with drinking problems?

( ) Yes ( ) No

Instructions:

Below are listed some statements about alcohol. You are to indicate whether you agree or disagree with the statements as stated based upon your own knowledge, experience and your feelings. The statements are listed under certain headings (example, *Psychological/Emotional*). These headings are for classification and scoring purposes only; do not be concerned with them. Please respond to *ALL* statements.

Psychological/Emotional Aspects

1. Alcohol-induced sleep over a period of time can lead to poor memory and concentration.
2. Alcohol is helpful for emotional pressures or problems.
3. Alcoholism is legally considered a form of mental illness.
4. Alcoholics tend to feel they are "worse off" than other people.
5. An alcoholic individual usually denies he has a drinking problem.
6. A person with a serious alcohol problem can "taper off" with some help and does not have to stop drinking completely (total abstinence).
7. Depression is a major cause of alcoholism.
8. Emotionally dependent people are usually more tolerant and understanding.
9. Alcoholics usually have mature personalities.
10. Alcohol is a sexual stimulant.
11. Alcoholics can be counseled and helped with some success.
12. The family of an alcoholic can be of great assistance or support in helping solve his drinking problems.

Social/Religious Aspects

13. One out of five persons reports that someone close to him has a drinking problem.
14. 70% of adult Americans drink alcohol to be sociable.
15. You're not an alcoholic if you do not drink before noon.
16. Most alcoholics drink alone.
17. The average person knows very few, if any, alcoholics.
18. In society most women are dependent, while most men are independent.
19. Today's young people do not drink as much as other younger generations.
20. One in every 10 executives has serious drinking problems.
21. Alcoholism among women is increasing.
22. In the U.S., alcoholism stands third in public health problems, coming after heart disease and cancer.
23. AA's purpose is for their members to stay sober and help others with alcohol problems.
24. Only three percent (3%) of alcoholics are on skid row.
25. Alcohol costs the American economy over 15 billion dollars per year.
26. A large number of alcoholics only drink beer.

Legal Aspects

27. A person can drive better after a few drinks.
28. Publicity about the dangers of drinking and driving is really over-played.
29. A recent Supreme Court case ruled that alcoholism is a disease, not a crime.
30. The police department is not a good resource for the alcoholic.
31. If alcohol were less readily available, there would be fewer alcoholics.

32. Most DWI convictions involve the drinking of hard liquor instead of beer.

33. Under law, convicted alcoholics should be given the opportunity for treatment.

34. Alcohol plays a role in about half, or 30,000, highway fatalities a year.

35. Half (½) of all murders and one-fourth (¼) of all suicides are alcohol-related.

36. It takes at least five or more drinks to impair one's ability to drive.

37. Alcoholism, by itself, rarely, if ever, causes death.

38. A blood-alcohol concentration of 0.20% or more constitutes legal drunkenness in most states.

Health Aspects

39. Alcohol can reduce the amount of work placed on the heart.

40. Alcohol can dissolve the fat in one's blood.

41. Alcohol, especially deep Burgundy wines, can build the blood.

42. Children of alcoholic parents will probably become alcoholics themselves.

43. The best way to get over a hangover is to drink coffee.

44. Alcohol is a drug.

45. The ability to drink large quantities of alcohol and "not show it" is still a sign of masculinity.

46. The best cure after a drinking spree is aspirin, bed rest, and solid food as soon as possible.

47. The "blackout" is considered a loss of memory during a drinking spree.

48. People tend to get drunker when they switch drinks.

49. DT's (the shakes) occur after the alcohol withdraws or leaves the body.

50. Alcohol is soothing for the stomach.

ANSWER KEY

Form A

1.	D	26.	D
2.	D	27.	A
3.	A	28.	A
4.	D	29.	D
5.	D	30.	D
6.	A	31.	A
7.	D	32.	D
8.	D	33.	A
9.	D	34.	A
10.	D	35.	A
11.	D	36.	A
12.	D	37.	D
13.	D	38.	A
14.	D	39.	D
15.	D	40.	D
16.	D	41.	D
17.	D	42.	D
18.	D	43.	A
19.	D	44.	D
20.	D	45.	D
21.	D	46.	D
22.	D	47.	D
23.	D	48.	A
24.	D	49.	A
25.	A	50.	D

Form B

1.	A	26.	A
2.	D	27.	D
3.	A	28.	D
4.	A	29.	A
5.	A	30.	D
6.	D	31.	D
7.	A	32.	D
8.	D	33.	A
9.	D	34.	A
10.	D	35.	A
11.	A	36.	D
12.	A	37.	D
13.	A	38.	D
14.	A	39.	D
15.	D	40.	D
16.	D	41.	D
17.	D	42.	D
18.	D	43.	D
19.	D	44.	A
20.	A	45.	D
21.	A	46.	A
22.	A	47.	A
23.	A	48.	D
24.	A	49.	A
25.	A	50.	D

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Rosenblatt, S.M.; Gross, M.M.; and Broman, M. Patients admitted for treatment of alcohol withdrawal syndromes: An epidemiological study. *Quarterly Journal of Studies on Alcohol*, 32:104-115, 1971. Negro and Caucasian admission rates to Kings County Psychiatric Hospital are detailed.

Rosenblatt, S.M.; Gross, M.M.; and Malenowski, Beverly. Marital status and multiple psychiatric admissions for alcoholism: A cross-validation. *Quarterly Journal of Studies on Alcohol*, 32(4):1092-1096, 1971. The relationship between disrupted marriage and multiple admission is characteristic of Black patients at and earlier age level than Whites.

Rubington, Earl. The changing skid row scene. *Quarterly Journal of Studies on Alcohol*, 32(1):123-135, 1971. Skid row is a vanishing social system with a declining population of deviants, now predominantly older Whites and young Negroes, and a rising rate of both violent crime and alcoholism.

Sabot, Lawrence M.; Gross, Milton M.; and Halpert, Eugene. A study of acute alcoholic psychoses in women. *British Journal of Addiction*, 63(1-2):29-49, 1968. A study was made of 65 chronic alcoholic female patients (18 White and 47 Black) with a diagnosis of acute alcoholic psychosis.

Schwarz, L.; and Fjeld, S.P. The alcoholic patient in the psychiatric hospital emergency room. *Quarterly Journal of Studies on Alcohol*, 30:104-111, 1969. Over a period of 8 weeks, 305 patients with alcohol-induced problems were admitted to the emergency room of the Malcolm Bliss Mental Health Center, St. Louis, Mo.: 70 percent were White.

Solomon, Neil. Maryland's mental hospitals six years after desegregation. *Maryland State Medical Journal*, 19(10):103, 1970. Hospital admissions to Maryland's mental hospitals six years after desegregation of Whites and non-Whites were compared: Alcoholic admissions increased from 20.1 to 28.7 percent. Proportionally, non-White state hospital admissions have continued to be twice as frequent as White.

Strayer, R. A study of the Negro alcoholic. *Quarterly Journal of Studies on Alcohol*, 22:111-123, 1961. The records of the Connecticut Commission on Alcoholism Clinic in Bridgeport were reviewed and from the extracted data a statistical description was compiled of 1308 White and Negro male and female admissions during a nine and one-half year period.

Sterne, M.W. Drinking patterns and alcoholism among American Negroes. In: Pittman, D.J., ed. *Alcoholism*. New York: Harper & Row, 1967. pp. 66-99. An overview of the literature concludes that where the entire Negro community has been studied, systematic and quantitative data are lacking; where these data are available, the studies pertain only to select groups.

Swift, Carolyn. "Utilization of Ministers as Alcohol Counselors: Increasing Treatment Alternatives in the Black Community." Presented at: North American Congress on Alcohol and Drug Problems (San Francisco, CA), December, 1974. 20 pp. Two pilot projects designed to test the practicality and effectiveness of using Black ministers as counselors for Black alcoholic offenders in a municipal court or jail setting are evaluated.

Viamontes, Jorge A., and Powell, Barbara J. Demographic characteristics of Black and White male alcoholics. *International Journal of the Addictions*, 9(3): 489-494, 1974. The authors surveyed charts of 100 Black and 100 White alcoholic males hospitalized in Malcolm Bliss Mental Health Center to explore possible demographic difference in alcoholism between Black and White males.

Vitols, M.M. Culture patterns of drinking in Negro and White alcoholics. *Diseases of the Nervous System*, 29(6):391-394, 1968. Data based on the admission of Negro alcoholic patients to North Carolina mental health facilities indicated a lower incidence of alcoholism among Negroes, but was not considered to be a true reflection of the actual incidence of alcoholism.

Zimberg, Sheldon; Lipscomb, Henry; and Davis, Elizabeth B. Sociopsychiatric treatment of alcoholism in an urban ghetto. *American Journal of Psychiatry*, 127 (12):106-110, 1971. The day-care program at the Harlem Hospital Center alcoholism unit is described.

FILM LIST

DIAL A-L-C-O-H-O-L Films, 1976, 15 minutes each, color; Senior high students; SALE: $142.50 each; RENT: Free loan; Sale: National Audiovisual Center (NAC), General Services Administration, Washington, D.C. 20409 (202) 763-7420; Rent: RHR Film Media, Inc., 1212 Avenue of The Americas, New York, N.Y. 10036 (212) 869-9540. "Dial A-L-C-O-H-O-L" is designed to enable young people, while still in adolescence, to clarify their own attitudes toward alcohol while understanding those of their parents and society. This will help them make responsible decisions regarding the use of alcohol so they will be able to function untroubled as adult drinkers or non-drinkers. This will also include the ability to cope with relatives and friends who abuse alcohol. There are four films in this series.

Rating: Good

THE LONG ROAD HOME Film, 20 minutes, Senior high through adult; Contact: Sea Island Comprehensive Health Care Corporation, Community Alcoholism Program, Route 3, Box 225, John's Island, South Carolina 29455. Produced by the Community Alcoholism Program of the Sea Island Comprehensive Health Care Corporation under a grant from the Commission on Alcohol and Drug Abuse. In the film, Jerome Smalls portrays Willie, a Sea Islands man who has alot going for him until he develops an alcohol problem. After a visit to CAP, Willie gets back on the road to being a happily married man without dependency on alcohol.

Rating: Very Good

NEW PERSPECTIVES ON ALCOHOLISM Films or videocassettes, 1974, 30 minutes, color, Senior high through adult; SALE: $9,200 retail, $5,800 government and non-profit; RENT: $100 each; Sale & Rent: Norman Southerby & Associates, P.O. Box 15403, Long Beach, California 90815 (213) 597-0709. With the help of many persons, including former U.S. Senator Harold Hughes, actors Hugh O'Brian and Robert Horton, author Jack Weiner, and nationally recognized physicians and educators, the series provides information to teachers, young persons, and the general public. The series, which is produced by KNXT-TV, the CBS affiliate in Los Angeles, advocates responsible use and decisions regarding alcohol. Individual titles in the series are as follows: *SCOPE OF THE PROBLEM* Former U.S. Senator Harold Hughes; *THE ULTIMATE ANSWER* Actor Hugh O'Brian; *TRAFFIC SAFETY* Actor Robert Horton; *CREATIVE APPROACHES* Educator Doyle Shields, B.D.; *ALCOHOL AND THE HEART* Myrvin Ellestad, M.D.; *ALCOHOL AND THE BRAIN* Ernest Noble, M.D.; *ALCOHOL AND MINORITIES* James Villaveces, M.D., and Joe Williams; *TREATMENT FOR ALCOHOLICS* Vernelle Fox, M.D.

Rating: Good

OSCAR Film, 1975, 8 minutes, color, Junior high through adult; SALE: $120; RENT: $30/3 days; Sale & Rent: Norm Southerby & Associates, P.O. Box 15403, Long Beach, California 90815 (213) 597-0709. A short alcohol film from a Black perspective produced by Bedford-Stuyvesant Alcoholic Treatment Center, Brooklyn, New York. Oscar lives in the city and experiences personal problems from his excessive drinking. Some of them include drinking on the job, arguing with his wife, and getting injured. Fortunately, Oscar finally finds the help he needs.

Rating: Good

TRIGGER FILMS FOR HEALTH (Series AE) Film, 1975, variable lengths, color, Junior high through senior high; SALE: $100; RENT: $25/day - $5/each additional day; Sale & Rent: University of Michigan, Television Center, 400 South Fourth Street, Ann Arbor, Michigan 48103 (313) 764-8298. Produced by the University of Michigan Television Center, these short films are designed to generate discussions about the use and abuse of alcohol. The purpose of these discussions is to help young people to test ideas, clarify values, and move toward realistic perceptions, personal choices, and more firm commitments with regard to the issue of drinking. Individual titles contained in the series are as follows:

THE GAME Length: 1:17. Some teenaged boys are playing basketball, and a younger boy stands watching–hoping to get into the game. He finally gets his wish to get into the action. Following the game the older youths break out some cold beer, but refuse to allow the youngster to participate.

This film asks why drinking is considered a privilege of age and opens for discussion several topics of alcohol and peer pressure, and example.

Rating: Good

THE BUDDIES Length: 0:48. Two young boys find a bottle of wine. One attempts to get his "buddy" to try some of it by taunting and daring him.

The film introduces the topic of peer pressures and asks how youth can deal with it.

Rating: Good